

All About Pets Animal Hospital Outpatient History Questionnaire

Appetite is: Good Fair Poor

Breathing is: Good Fair Poor

Ears are: Good Fair Poor

Activity is: Good Fair Poor

Skin/hair condition is: Good Fair Poor

Nails are: Good Fair Poor

For cats only: Is your pet?

Indoors only Outdoors Only Both

Any coughing or sneezing? Yes No

If yes: How long? _____

Any vomiting or diarrhea? Yes No

If yes: How long? _____

Any changes in water consumption? Yes No

If yes: How long? _____

Any changes in urinary habits/accidents? Yes No

If yes: How long? _____

Any itching or licking? Yes No

If yes: How long? _____

Any scooting? (rubbing butt on floor) Yes No

If yes: How long? _____

Any lumps? Yes No

If yes: How long? _____

Current Diet: _____ Quantity per day - Canned: _____ Dry: _____

What medications are you currently giving? _____

Vitamins or Supplements? _____

Heartworm preventative? _____ Flea Control? _____

Other over the counter medications? _____

Do you need a refill? If yes, what medications: _____

Does your pet experience stiffness or difficulty getting up or down stairs? Yes No

Does your pet hesitate before jumping onto the bed or couch or in/out of the car? Yes No

Does your pet sometimes seem stiff or shaky when rising or walking? Yes No

Does your pet show signs of discomfort or pain with any activity? Yes No

Does your dog seem to be lagging behind during walks? Yes No

Does your pet display any behaviors which are concerning to you? Yes No

What does your pet do for activities? _____

Any other problems you would like to discuss? Please explain: _____

Client Signature: _____ Date: _____

Do not write in box!
Patient Label Only

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Document Description:

Medical Record Label

Printer: 71, 94, 95, 96

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